SENATE BILL 25-270

BY SENATOR(S) Bridges and Amabile, Cutter, Gonzales J., Hinrichsen, Kipp, Michaelson Jenet, Sullivan, Wallace, Winter F., Coleman;
also REPRESENTATIVE(S) Bird and Sirota, McCluskie, Clifford.

CONCERNING NURSING FACILITY FEES COLLECTED BY THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE, AND, IN CONNECTION THEREWITH, AUTHORIZING THE ENTERPRISE TO PROVIDE ADDITIONAL SERVICES TO NURSING FACILITIES IN EXCHANGE FOR THE FEES COLLECTED AND MAKING AND REDUCING APPROPRIATIONS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25.5-4-402.4, **amend** (2) introductory portion, (2)(a), (2)(c) introductory portion, (2)(c)(V), (2)(c)(VI), (2)(d) introductory portion, (2)(e), (2)(f), (2)(g), (3)(a), (3)(c)(I), (3)(d)(I), (3)(d)(II), (3)(d)(III), (3)(d)(V), (4)(b) introductory portion, (4)(b)(II), (4)(b)(III), (4)(c)(I) introductory portion, (4)(c)(II)(C), (4)(c)(III) introductory portion, (4)(c)(III)(E), (4)(c)(III)(F), (4)(e), (4)(f), (5)(a), (5)(b) introductory portion, (5)(b)(IV) introductory portion, (5)(b)(VI)(B), (5)(c)(I)(A), (5)(c)(II)(C), (5)(c)(III), (5)(c)(V), (6)(a)(I), (6)(b) introductory portion, (6)(b)(II), (6)(b)(III)(A), (6)(b)(III)(B), (6)(c), (7)(b), (7)(d)(I),

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(7)(d)(II), (7)(d)(III), (7)(d)(IX), (7)(d)(X), (7)(e) introductory portion, (7)(e)(II), (7)(e)(III) introductory portion, and (7)(e)(IV); **amend as they exist until July 1, 2025,** (2)(d)(I), (4)(a) introductory portion, and (4)(g); and **add** (2)(c)(V.5), (2)(c)(V.7), (2)(d.5), (2)(d.7), (3)(c)(IV), (3)(c)(V), (4.5), (4.7), (5.5), (5.7), (6)(a)(IV), (6)(a)(V), (6)(b.5), (6)(c.5), (6)(c.7), (7)(e)(II.5), (7)(e)(II.7), (7)(e)(III.5), (7)(e)(III.7), (7)(h), (7.5), and (9) as follows:

25.5-4-402.4. Healthcare affordability and sustainability hospital provider fee - healthcare affordability and sustainability nursing facility provider fee - healthcare affordability and sustainability intermediate care facility fee - Colorado healthcare affordability and sustainability enterprise - federal waiver - funds created - reports - rules - legislative declaration - repeal. (2) **Legislative declaration.** The general assembly ~~hereby~~ finds and declares that:

(a) The state and the providers of publicly funded medical services, and hospitals, NURSING FACILITY PROVIDERS, AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES in particular, share a common commitment to comprehensive health-care reform;

(c) This section is enacted as part of a comprehensive health-care reform and is intended to provide the following services and benefits to hospitals, NURSING FACILITY PROVIDERS, INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, and individuals:

(V) Expanding access to high-quality, affordable health care for low-income and uninsured populations; ~~and~~

(V.5) SUSTAINING OR INCREASING THE REIMBURSEMENT FOR PROVIDING MEDICAL CARE UNDER THE STATE'S MEDICAL ASSISTANCE PROGRAM FOR NURSING FACILITY PROVIDERS AND MAKING SUPPLEMENTAL MEDICAID PAYMENTS TO NURSING FACILITY PROVIDERS;

(V.7) MAINTAINING THE QUALITY AND CONTINUITY OF SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES; AND

(VI) Providing the additional business services specified in subsection (4)(a)(IV) of this section to hospitals that pay the healthcare

affordability and sustainability HOSPITAL PROVIDER fee charged and collected as authorized by subsection (4) of this section by the Colorado healthcare affordability and sustainability enterprise created in subsection (3)(a) of this section;

(d) The Colorado healthcare affordability and sustainability enterprise provides business services to hospitals when, in exchange for payment of healthcare affordability and sustainability HOSPITAL PROVIDER fees by hospitals, it:

(I) Obtains federal matching money and returns both the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and the federal matching money to hospitals to increase reimbursement rates to hospitals for providing medical care under the state medical assistance program and the Colorado indigent care program and to increase the number of individuals covered by public medical assistance; and

(d.5) THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE PROVIDES BUSINESS SERVICES TO NURSING FACILITY PROVIDERS WHEN, IN EXCHANGE FOR PAYMENT OF NURSING FACILITY PROVIDER FEES, IT OBTAINS FEDERAL MATCHING MONEY AND RETURNS BOTH THE NURSING FACILITY PROVIDER FEE AND THE FEDERAL MATCHING MONEY TO NURSING FACILITY PROVIDERS TO SUSTAIN OR INCREASE REIMBURSEMENT RATES AND MAKE SUPPLEMENTAL MEDICAID PAYMENTS TO NURSING FACILITY PROVIDERS;

(d.7) THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE PROVIDES BUSINESS SERVICES TO INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES WHEN, IN EXCHANGE FOR PAYMENT OF INTERMEDIATE CARE FACILITY FEES, IT OBTAINS FEDERAL MATCHING MONEY AND RETURNS BOTH THE INTERMEDIATE CARE FACILITY FEE AND THE FEDERAL MATCHING MONEY TO INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES TO SUSTAIN OR INCREASE REIMBURSEMENT RATES AND MAKE SUPPLEMENTAL MEDICAID PAYMENTS TO SUCH INTERMEDIATE CARE FACILITIES;

(e) It is necessary, appropriate, and in the best interest of the state to acknowledge that by providing the business services specified in ~~subsections (2)(d)(I) and (2)(d)(II)~~ SUBSECTIONS (2)(d) TO (2)(d.7) of this

section, the Colorado healthcare affordability and sustainability enterprise engages in an activity conducted in the pursuit of a benefit, gain, or livelihood and therefore operates as a business;

(f) Consistent with the determination of the Colorado supreme court in *Nicholl v. E-470 Public Highway Authority,* 896 P.2d 859 (Colo. 1995), that the power to impose taxes is inconsistent with enterprise status under section 20 of article X of the state constitution, it is the conclusion of the general assembly that the healthcare affordability and sustainability HOSPITAL PROVIDER fee, THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE, AND THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE charged and collected by the Colorado healthcare affordability and sustainability enterprise ~~is a fee~~ ARE FEES, not ~~a tax~~ TAXES, because the ~~fee is~~ FEES ARE imposed for the specific purposes of allowing the enterprise to defray the costs of providing the business services specified in ~~subsections (2)(d)(I) and (2)(d)(II)~~ SUBSECTIONS (2)(d) TO (2)(d.7) of this section to hospitals, NURSING FACILITY PROVIDERS, AND INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES that pay the ~~fee~~ FEES and ~~is~~ ARE collected at rates that are reasonably calculated based on the benefits received by those hospitals, NURSING FACILITY PROVIDERS, AND INTERMEDIATE CARE FACILITIES; and

(g) So long as the Colorado healthcare affordability and sustainability enterprise qualifies as an enterprise for purposes of section 20 of article X of the state constitution, the revenues from the ~~healthcare affordability and sustainability fee~~ FEES charged and collected by the enterprise are not state fiscal year spending, as defined in section 24-77-102 (17), or state revenues, as defined in section 24-77-103.6 (6)(c), and do not count against either the state fiscal year spending limit imposed by section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(3) **Colorado healthcare affordability and sustainability enterprise.** (a) The Colorado healthcare affordability and sustainability enterprise ~~referred to in this section as the "enterprise",~~ is created. The enterprise is and operates as a government-owned business within the state department for the purpose of:

(I) Charging and collecting:

(A) The ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee;

(B) THE NURSING FACILITY PROVIDER FEE; AND

(C) THE INTERMEDIATE CARE FACILITY FEE;

(II) Leveraging ~~healthcare affordability and sustainability~~ REVENUE FROM THE HOSPITAL PROVIDER fee, ~~revenue~~ THE NURSING FACILITY PROVIDER FEE, AND THE INTERMEDIATE CARE FACILITY FEE to obtain federal matching money; and

(III) Utilizing and deploying:

(A) The ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue and federal matching money to provide the business services specified in subsections (2)(d)(I) and (2)(d)(II) of this section to hospitals that pay the healthcare affordability and sustainability fee;

(B) THE NURSING FACILITY PROVIDER FEE REVENUE AND ANY FEDERAL MATCHING MONEY TO PROVIDE THE BUSINESS SERVICES SPECIFIED IN SUBSECTION (2)(d.5) OF THIS SECTION TO NURSING FACILITY PROVIDERS THAT PAY THE NURSING FACILITY PROVIDER FEE; AND

(C) THE INTERMEDIATE CARE FACILITY FEE REVENUE AND ANY FEDERAL MATCHING MONEY TO PROVIDE THE BUSINESS SERVICES SPECIFIED IN SUBSECTION (2)(d.7) OF THIS SECTION TO INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES THAT PAY THE INTERMEDIATE CARE FACILITY FEE.

(c) (I) The repeal of the hospital provider fee program, as it existed pursuant to section 25.5-4-402.3 before its repeal, effective July 1, 2017, by Senate Bill 17-267, enacted in 2017, and the creation of the Colorado healthcare affordability and sustainability enterprise as a new enterprise to charge and collect a new healthcare affordability and sustainability HOSPITAL PROVIDER fee as authorized by subsection (4) of this section and provide ~~healthcare affordability and sustainability~~ fee-funded business services to hospitals that replace and supplement services previously funded by THE REPEALED hospital provider fees is the creation of a new government-owned business that provides business services to hospitals as

a new enterprise for purposes of section 20 of article X of the state constitution, does not constitute the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution or section 24-77-103.6 (6)(b)(II), and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(IV) THE REPEAL OF THE NURSING FACILITY PROVIDER FEE PROGRAM, AS IT EXISTED IN SECTION 25.5-6-203 (1) BEFORE ITS REPEAL, EFFECTIVE MAY 1, 2025, BY SENATE BILL 25-270, ENACTED IN 2025, AND THE ENTERPRISE'S ABILITY TO CHARGE AND COLLECT A NEW HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE AS AUTHORIZED BY SUBSECTION (4.5) OF THIS SECTION AND PROVIDE FEE-FUNDED BUSINESS SERVICES TO NURSING FACILITY PROVIDERS THAT REPLACE AND SUPPLEMENT SERVICES PREVIOUSLY FUNDED BY THE NURSING FACILITY PROVIDER FEE DOES NOT CONSTITUTE CREATION OF A NEW ENTERPRISE OR THE QUALIFICATION OF AN EXISTING GOVERNMENT-OWNED BUSINESS AS AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION, SECTION 24-77-103.6 (6)(b)(II), OR SECTION 24-77-108, AND, THEREFORE, DOES NOT REQUIRE OR AUTHORIZE ADJUSTMENT OF THE STATE FISCAL YEAR SPENDING LIMIT CALCULATED PURSUANT TO SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR THE EXCESS STATE REVENUES CAP, AS DEFINED IN SECTION 24-77-103.6 (6)(b)(I), AND DOES NOT REQUIRE VOTER APPROVAL.

(V) THE REPEAL OF THE INTERMEDIATE CARE FACILITY SERVICE FEE PROGRAM, AS IT EXISTED IN SECTION 25.5-6-204 (1)(c)(I) BEFORE ITS REPEAL, EFFECTIVE MAY 1, 2025, BY SENATE BILL 25-270, ENACTED IN 2025, AND THE ENTERPRISE'S ABILITY TO CHARGE AND COLLECT A NEW HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE AS AUTHORIZED BY SUBSECTION (4.7) OF THIS SECTION AND PROVIDE FEE-FUNDED BUSINESS SERVICES TO INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES THAT REPLACE AND SUPPLEMENT SERVICES PREVIOUSLY FUNDED BY THE INTERMEDIATE CARE FACILITY SERVICE FEE DOES NOT CONSTITUTE CREATION OF A NEW ENTERPRISE OR THE QUALIFICATION OF AN EXISTING GOVERNMENT-OWNED BUSINESS AS AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION, SECTION

24-77-103.6 (6)(b)(II), OR SECTION 24-77-108, AND, THEREFORE, DOES NOT REQUIRE OR AUTHORIZE ADJUSTMENT OF THE STATE FISCAL YEAR SPENDING LIMIT CALCULATED PURSUANT TO SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION OR THE EXCESS STATE REVENUES CAP, AS DEFINED IN SECTION 24-77-103.6 (6)(b)(I), AND DOES NOT REQUIRE VOTER APPROVAL.

(d) The enterprise's primary powers and duties are:

(I) To charge and collect:

(A) The ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee as specified in subsection (4) of this section;

(B) THE NURSING FACILITY PROVIDER FEE AS SPECIFIED IN SUBSECTION (4.5) OF THIS SECTION; AND

(C) THE INTERMEDIATE CARE FACILITY FEE AS SPECIFIED IN SUBSECTION (4.7) OF THIS SECTION;

(II) To leverage ~~healthcare affordability and sustainability~~ REVENUE FROM THE HOSPITAL PROVIDER fee, ~~revenue collected~~ THE NURSING FACILITY PROVIDER FEE, AND THE INTERMEDIATE CARE FACILITY FEE to obtain federal matching money, working with or through the state department and the state board to the extent required by federal law or otherwise necessary;

(III) To expend:

(A) ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue, matching federal money, and any other money from the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee cash fund as specified in subsections (4) and (5) of this section;

(B) NURSING FACILITY PROVIDER FEE REVENUE, MATCHING FEDERAL MONEY, AND ANY OTHER MONEY FROM THE NURSING FACILITY PROVIDER FEE CASH FUND AS SPECIFIED IN SUBSECTION (5.5) OF THIS SECTION; AND

(C) INTERMEDIATE CARE FACILITY FEE REVENUE, MATCHING FEDERAL MONEY, AND ANY OTHER MONEY FROM THE INTERMEDIATE CARE FACILITY FEE CASH FUND AS SPECIFIED IN SUBSECTION (5.7) OF THIS SECTION;

(V) To enter into agreements with the state department to the extent necessary to collect and expend ~~healthcare affordability and sustainability~~ REVENUE FROM THE HOSPITAL PROVIDER fee, ~~revenue~~ THE NURSING FACILITY PROVIDER FEE, AND THE INTERMEDIATE CARE FACILITY FEE;

(4) **Healthcare affordability and sustainability hospital provider fee.** (a) For the fiscal year commencing July 1, 2017, and for each fiscal year thereafter, the enterprise is authorized to charge and collect a healthcare affordability and sustainability HOSPITAL PROVIDER fee, as described in 42 CFR 433.68 (b), on outpatient and inpatient services provided by all licensed or certified hospitals ~~referred to in this section as "hospitals",~~ for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article 4 and articles 5 and 6 of this title 25.5 ~~referred to in this section as the "state medical assistance program",~~ and the Colorado indigent care program described in part 1 of article 3 of this title 25.5, referred to in this section as the "Colorado indigent care program". If the amount of ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue collected exceeds the federal net patient revenue-based limit on the amount of such fee revenue that may be collected, requiring repayment to the federal government of excess federal matching money received, hospitals that received such excess federal matching money shall be responsible for repaying the excess federal money and any associated federal penalties to the federal government. The enterprise shall use the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue to:

(b) The enterprise shall recommend for approval and establishment by the state board the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee that it intends to charge and collect. The state board must establish the final amount of the fee by rules promulgated in accordance with article 4 of title 24. The state board shall not establish any amount that exceeds the federal limit for such fees. The state board may deviate from the recommendations of the enterprise, but shall express in writing the reasons for any deviations. In establishing the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(II) Establish the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee so that the amount collected from the fee and federal matching funds associated with the fee are sufficient to pay

for the items described in subsection (4)(a) of this section, but nothing in this subsection (4)(b)(II) requires the state board to increase the fee above the amount recommended by the enterprise; and

(III) For the 2017-18 fiscal year, establish the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee so that the amount collected from the fee is approximately equal to the sum of the amounts of the appropriations specified for the fee in the general appropriation act, Senate Bill 17-254, enacted in 2017, and any other supplemental appropriation act.

(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the enterprise, acting in concert with or through an agreement with the state department if required by federal law, may seek a waiver from the broad-based ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee requirement or the uniform ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee requirement, or both. In addition, the enterprise, acting in concert with or through an agreement with the state department if required by federal law, shall seek any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation of a health-care delivery system reform incentive payments program as described in subsection (8) of this section. Subject to federal approval and to minimize the financial impact on certain hospitals, the enterprise may exempt from payment of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee certain types of hospitals, including but not limited to:

(II) In determining whether a hospital may be excluded, the enterprise shall use one or more of the following criteria:

(C) A hospital whose inclusion or exclusion would not significantly affect the net benefit to hospitals paying the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee; or

(III) The enterprise may reduce the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee for certain hospitals to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the enterprise may reduce the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee, the enterprise shall use one or more of the following criteria:

(E) If the hospital paid a reduced ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee, the reduced fee would not significantly affect the net benefit to hospitals paying the ~~healthcare affordability and sustainability~~ fee; or

(F) The hospital is required not to pay a reduced ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee as a condition of federal approval.

(e) (I) The enterprise shall establish policies on the calculation, assessment, and timing of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee. The enterprise shall assess the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee on a schedule to be set by the enterprise board as provided in subsection (7)(d) of this section. The periodic ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee payments from a hospital and the enterprise's reimbursement to the hospital under subsections (5)(b)(I) and (5)(b)(II) of this section are due as nearly simultaneously as feasible; except that the enterprise's reimbursement to the hospital is due no more than two days after the periodic ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee payment is received from the hospital. The ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee must be imposed on each hospital even if more than one hospital is owned by the same entity. The fee must be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

(II) The enterprise is authorized to refund any unused portion of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee. For any portion of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee that has been collected by the enterprise but for which the enterprise has not received federal matching funds, the enterprise shall refund back to the hospital that paid the fee the amount of that portion of the fee within five business days after the fee is collected.

(III) The enterprise shall establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee. Notwithstanding the provisions of part 2 of article 72 of title 24 or subsection (7)(f) of this section, information provided to the enterprise pursuant to this section is confidential and is not a public record.

Nonetheless, the enterprise may prepare and release summaries of the reports to the public.

(f) A hospital shall not include any amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee as a separate line item in its billing statements.

(g) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(d) of this section.

(4.5) **Healthcare affordability and sustainability nursing facility provider fee.** (a) BEGINNING ON MAY 1, 2025, THE ENTERPRISE IS AUTHORIZED TO CHARGE AND COLLECT A HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE ON HEALTH-CARE ITEMS OR SERVICES PROVIDED BY NURSING FACILITY PROVIDERS FOR THE PURPOSE OF OBTAINING FEDERAL FINANCIAL PARTICIPATION UNDER THE STATE MEDICAL ASSISTANCE PROGRAM AS DESCRIBED IN THIS ARTICLE 4 AND ARTICLES 5 AND 6 OF THIS TITLE 25.5. THE ENTERPRISE SHALL USE THE NURSING FACILITY PROVIDER FEE REVENUE TO PROVIDE A BUSINESS SERVICE TO NURSING FACILITY PROVIDERS BY SUSTAINING OR INCREASING REIMBURSEMENT FOR PROVIDING MEDICAL CARE UNDER THE STATE MEDICAL ASSISTANCE PROGRAM FOR NURSING FACILITY PROVIDERS AND MAKING SUPPLEMENTAL MEDICAID PAYMENTS TO NURSING FACILITY PROVIDERS, AS SPECIFIED BY THE PRIORITY OF THE USES OF THE NURSING FACILITY PROVIDER FEE REVENUE SET FORTH IN SUBSECTION (5.5)(b) OF THIS SECTION.

(b) THE ENTERPRISE SHALL RECOMMEND FOR APPROVAL AND ESTABLISHMENT BY THE STATE BOARD THE AMOUNT OF THE NURSING FACILITY PROVIDER FEE THAT IT INTENDS TO CHARGE AND COLLECT. THE STATE BOARD MUST ESTABLISH THE FINAL AMOUNT OF THE FEE BY RULE. THE STATE BOARD SHALL NOT ESTABLISH ANY AMOUNT THAT EXCEEDS THE FEDERAL LIMIT FOR SUCH FEES. THE STATE BOARD MAY DEVIATE FROM THE RECOMMENDATIONS OF THE ENTERPRISE, BUT SHALL EXPRESS IN WRITING THE REASONS FOR ANY DEVIATIONS. IN ESTABLISHING THE AMOUNT OF THE FEE AND IN PROMULGATING THE RULES GOVERNING THE FEE, THE STATE

BOARD SHALL:

(I) CONSIDER RECOMMENDATIONS OF THE ENTERPRISE; AND

(II) ESTABLISH THE AMOUNT OF THE NURSING FACILITY PROVIDER FEE SO THAT THE AMOUNT COLLECTED FROM THE FEE AND FEDERAL MATCHING FUNDS ASSOCIATED WITH THE FEE ARE SUFFICIENT TO PAY FOR THE ITEMS DESCRIBED IN SUBSECTION (4.5)(a) OF THIS SECTION, BUT NOTHING IN THIS SUBSECTION (4.5)(b)(II) REQUIRES THE STATE BOARD TO INCREASE THE FEE ABOVE THE AMOUNT RECOMMENDED BY THE ENTERPRISE.

(c) THE ENTERPRISE SHALL NOT CHARGE OR COLLECT THE NURSING FACILITY PROVIDER FEE IN THE ABSENCE OF THE FEDERAL GOVERNMENT'S APPROVAL OF A STATE MEDICAID PLAN AMENDMENT AUTHORIZING FEDERAL FINANCIAL PARTICIPATION FOR THE NURSING FACILITY PROVIDER FEE. THE ENTERPRISE MAY ALTER THE PROCESS PRESCRIBED IN THIS SUBSECTION (4.5) TO THE EXTENT NECESSARY TO MEET FEDERAL REQUIREMENTS AND TO OBTAIN FEDERAL APPROVAL. THE ENTERPRISE MAY LOWER THE AMOUNT OF THE NURSING FACILITY PROVIDER FEE CHARGED TO CERTAIN NURSING FACILITY PROVIDERS TO MEET THE REQUIREMENTS OF 42 CFR 433.68 (e) AND TO OBTAIN FEDERAL APPROVAL.

(d) (I) IN ACCORDANCE WITH THE REDISTRIBUTIVE METHOD SET FORTH IN 42 CFR 433.68 (e)(1) AND (e)(2), THE ENTERPRISE, ACTING IN CONCERT WITH OR THROUGH AN AGREEMENT WITH THE STATE DEPARTMENT IF REQUIRED BY FEDERAL LAW, MAY SEEK A WAIVER FROM THE BROAD-BASED NURSING FACILITY PROVIDER FEE REQUIREMENT OR THE UNIFORM NURSING FACILITY PROVIDER FEE REQUIREMENT, OR BOTH.

(II) SUBJECT TO FEDERAL APPROVAL AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN NURSING FACILITY PROVIDERS, THE ENTERPRISE MAY EXEMPT FROM PAYMENT OF THE NURSING FACILITY PROVIDER FEE CERTAIN TYPES OF NURSING PROVIDER FACILITIES, INCLUDING BUT NOT LIMITED TO:

(A) A FACILITY OPERATED AS A CONTINUING CARE RETIREMENT COMMUNITY THAT PROVIDES A CONTINUUM OF SERVICES BY ONE OPERATIONAL ENTITY PROVIDING INDEPENDENT LIVING SERVICES, ASSISTED LIVING SERVICES, AND SKILLED NURSING CARE ON A SINGLE, CONTIGUOUS CAMPUS. ASSISTED LIVING SERVICES INCLUDE AN ASSISTED LIVING

RESIDENCE AS DEFINED IN SECTION 25-27-102 OR A FACILITY THAT PROVIDES ASSISTED LIVING SERVICES ON-SITE, TWENTY-FOUR HOURS PER DAY, SEVEN DAYS PER WEEK.

(B) A SKILLED NURSING FACILITY OWNED AND OPERATED BY THE STATE;

(C) A NURSING FACILITY THAT IS A DISTINCT PART OF A FACILITY THAT IS LICENSED AS A GENERAL ACUTE CARE HOSPITAL; AND

(D) A FACILITY THAT HAS FORTY-FIVE OR FEWER LICENSED BEDS.

(e) (I) THE ENTERPRISE SHALL ESTABLISH POLICIES ON THE CALCULATION, ASSESSMENT, AND TIMING OF THE NURSING FACILITY PROVIDER FEE. THE ENTERPRISE SHALL ASSESS THE NURSING FACILITY PROVIDER FEE ON A MONTHLY BASIS. THE NURSING FACILITY PROVIDER FEE PAYMENTS FROM A NURSING FACILITY PROVIDER AND THE ENTERPRISE'S REIMBURSEMENT AND SUPPLEMENTAL PAYMENTS TO THE NURSING FACILITY PROVIDER UNDER SUBSECTION (5.5)(b) OF THIS SECTION ARE DUE AS NEARLY SIMULTANEOUSLY AS FEASIBLE; EXCEPT THAT THE ENTERPRISE'S REIMBURSEMENT AND SUPPLEMENTAL PAYMENTS TO THE NURSING FACILITY PROVIDER ARE DUE NO MORE THAN FIFTEEN DAYS AFTER THE NURSING FACILITY PROVIDER FEE PAYMENT IS RECEIVED FROM THE NURSING FACILITY PROVIDER.

(II) THE ENTERPRISE SHALL ESTABLISH REQUIREMENTS FOR THE REPORTS THAT NURSING FACILITY PROVIDERS MUST SUBMIT TO THE ENTERPRISE TO ALLOW THE ENTERPRISE TO CALCULATE THE AMOUNT OF THE NURSING FACILITY PROVIDER FEE, INCLUDING A REQUIREMENT THAT EACH NURSING FACILITY PROVIDER REPORT ANNUALLY ITS TOTAL NUMBER OF DAYS OF CARE PROVIDED TO NONMEDICARE RESIDENTS. NOTWITHSTANDING PART 2 OF ARTICLE 72 OF TITLE 24 OR SUBSECTION (7)(f) OF THIS SECTION, INFORMATION PROVIDED TO THE ENTERPRISE PURSUANT TO THIS SUBSECTION (4.5)(e)(II) IS CONFIDENTIAL AND IS NOT A PUBLIC RECORD. NONETHELESS, THE ENTERPRISE MAY PREPARE AND RELEASE SUMMARIES OF THE REPORTS TO THE PUBLIC.

(f) A NURSING FACILITY PROVIDER SHALL NOT INCLUDE ANY AMOUNT OF THE NURSING FACILITY PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.

(g) (I) THE STATE BOARD SHALL ADOPT ANY RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS SECTION. PRIOR TO SUBMITTING ANY PROPOSED RULES CONCERNING THE ADMINISTRATION OR IMPLEMENTATION OF THE NURSING FACILITY PROVIDER FEE TO THE STATE BOARD, THE ENTERPRISE SHALL CONSULT WITH THE STATE BOARD ON THE PROPOSED RULES AS SPECIFIED IN SUBSECTION (7)(h) OF THIS SECTION.

(4.7) **Healthcare affordability and sustainability intermediate care facility fee.** (a) BEGINNING ON MAY 1, 2025, THE ENTERPRISE IS AUTHORIZED TO CHARGE AND COLLECT A HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE ON BOTH PRIVATELY OWNED AND STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES FOR THE PURPOSE OF MAINTAINING THE QUALITY AND CONTINUITY OF SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES. THE ENTERPRISE SHALL USE THE INTERMEDIATE CARE FACILITY FEE REVENUE TO PROVIDE A BUSINESS SERVICE TO SUCH INTERMEDIATE CARE FACILITIES BY SUSTAINING OR INCREASING REIMBURSEMENT TO SUCH FACILITIES, AS SPECIFIED IN SUBSECTION (5.7)(b) OF THIS SECTION.

(b) THE ENTERPRISE SHALL RECOMMEND FOR APPROVAL AND ESTABLISHMENT BY THE STATE BOARD THE AMOUNT OF THE INTERMEDIATE CARE FACILITY FEE THAT IT INTENDS TO CHARGE AND COLLECT, WHICH MUST NOT EXCEED FIVE PERCENT OF THE TOTAL COSTS INCURRED BY ALL INTERMEDIATE CARE FACILITIES FOR THE FISCAL YEAR IN WHICH THE FEE IS CHARGED. THE STATE BOARD MUST ESTABLISH THE FINAL AMOUNT OF THE FEE BY RULE. THE STATE BOARD SHALL NOT ESTABLISH ANY AMOUNT THAT EXCEEDS THE FEDERAL LIMIT FOR SUCH FEES. THE STATE BOARD MAY DEVIATE FROM THE RECOMMENDATIONS OF THE ENTERPRISE, BUT SHALL EXPRESS IN WRITING THE REASONS FOR ANY DEVIATIONS.

(c) THE ENTERPRISE MAY ALTER THE PROCESS PRESCRIBED IN THIS SUBSECTION (4.7) TO THE EXTENT NECESSARY TO MEET FEDERAL REQUIREMENTS.

(d) (I) THE ENTERPRISE SHALL ESTABLISH POLICIES ON THE CALCULATION, ASSESSMENT, AND TIMING OF THE INTERMEDIATE CARE FACILITY FEE.

(II) THE ENTERPRISE SHALL ESTABLISH REQUIREMENTS FOR THE REPORTS THAT INTERMEDIATE CARE FACILITIES MUST SUBMIT TO THE ENTERPRISE TO ALLOW THE ENTERPRISE TO CALCULATE THE AMOUNT OF THE INTERMEDIATE CARE FACILITY FEE. NOTWITHSTANDING PART 2 OF ARTICLE 72 OF TITLE 24 OR SUBSECTION (7)(f) OF THIS SECTION, INFORMATION PROVIDED TO THE ENTERPRISE PURSUANT TO THIS SUBSECTION (4.7)(d)(II) IS CONFIDENTIAL AND IS NOT A PUBLIC RECORD. NONETHELESS, THE ENTERPRISE MAY PREPARE AND RELEASE SUMMARIES OF THE REPORTS TO THE PUBLIC.

(e) THE STATE BOARD SHALL ADOPT ANY RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS SECTION. PRIOR TO SUBMITTING ANY PROPOSED RULES CONCERNING THE ADMINISTRATION OR IMPLEMENTATION OF THE INTERMEDIATE CARE FACILITY FEE TO THE STATE BOARD, THE ENTERPRISE SHALL CONSULT WITH THE STATE BOARD ON THE PROPOSED RULES AS SPECIFIED IN SUBSECTION (7)(h) OF THIS SECTION.

(5) **Healthcare affordability and sustainability hospital provider fee cash fund.** (a) (I) Any healthcare affordability and sustainability HOSPITAL PROVIDER fee collected pursuant to this section by the enterprise must be transmitted to the state treasurer, who shall credit the fee to the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund, which fund is ~~hereby~~ created. ~~and referred to in this section as the "fund".~~ The state treasurer shall credit all interest and income derived from the deposit and investment of money in the HOSPITAL PROVIDER FEE CASH fund to the fund. The state treasurer shall invest any money in the HOSPITAL PROVIDER FEE CASH fund not expended for the purposes specified in subsection (5)(b) of this section as provided by law. Money in the HOSPITAL PROVIDER FEE CASH fund shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in this subsection (5) and in subsection (4) of this section.

(II) (A) THE FUND CREATED IN THIS SUBSECTION (5)(a) WAS RENAMED AS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE CASH FUND IN SENATE BILL 25-270, ENACTED IN 2025. FOR PURPOSES OF THE ANNUAL GENERAL APPROPRIATION ACTS FOR THE 2024-25 AND 2025-26 STATE FISCAL YEARS, THE CASH FUNDS APPROPRIATIONS MADE TO THE DEPARTMENT OF HEALTH CARE POLICY AND

FINANCING FROM THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE CASH FUND, AS THE FUND WAS NAMED PRIOR TO THE ENACTMENT OF SENATE BILL 25-270, ENACTED IN 2025, ARE FROM THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE CASH FUND, AS RENAMED BY SENATE BILL 25-270, ENACTED IN 2025.

(B) THIS SUBSECTION (5)(a)(II) IS REPEALED, EFFECTIVE JULY 1, 2027.

(b) All money in the HOSPITAL PROVIDER FEE CASH fund is subject to federal matching as authorized under federal law and, subject to annual appropriation by the general assembly, shall be expended by the enterprise for the following purposes:

(IV) Subject to available revenue from the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and federal matching funds, to expand eligibility for public medical assistance by:

(VI) To pay the enterprise's actual administrative costs of implementing and administering this section, including but not limited to the following costs:

(B) The enterprise's actual costs related to implementing and maintaining the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee, including personal services, operating, and consulting expenses;

(c) **ARPA home- and community-based services account.** (I) (A) There is created the "ARPA home- and community-based services account" within the HOSPITAL PROVIDER FEE CASH fund, referred to in this subsection (5)(c) as the "ARPA account". Notwithstanding any other provision of this section to the contrary, money in the ARPA account as a result of fund savings and federal matching dollars must be used in accordance with section 9817 of the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, as amended, referred to in this section as "ARPA", to implement or supplement the implementation of home- and community-based services under the medical assistance program pursuant to the provisions of part 18 of article 6 of this title 25.5.

(II) (C) If the fund savings due to the enhanced federal match under

ARPA is less than the amount transferred to the ARPA account under subsection (5)(c)(II)(A) of this section, then the state department shall notify the state treasurer of the amount by which the transfer exceeds the savings. The state treasurer shall transfer this amount from the ARPA account to the HOSPITAL PROVIDER FEE CASH fund.

(III) The state treasurer shall credit all interest and income derived from the money in the ARPA account to the HOSPITAL PROVIDER FEE CASH fund.

(V) Money in the ARPA account remains in the ARPA account until the end of the spending period authorized under ARPA, at which time money remaining in the ARPA account becomes part of the HOSPITAL PROVIDER FEE CASH fund.

(5.5) **Healthcare affordability and sustainability nursing facility provider fee cash fund.** (a) ALL HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING PROVIDER FEES COLLECTED PURSUANT TO THIS SECTION BY THE ENTERPRISE MUST BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE FEE TO THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE CASH FUND, WHICH FUND IS CREATED. THE STATE TREASURER SHALL CREDIT ALL INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND TO THE NURSING FACILITY PROVIDER FEE CASH FUND. THE STATE TREASURER SHALL INVEST ANY MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND NOT EXPENDED FOR THE PURPOSES SPECIFIED IN SUBSECTIONS (4.5)(a) AND (5.5)(b) OF THIS SECTION AS PROVIDED BY LAW. MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND SHALL NOT BE TRANSFERRED TO ANY OTHER FUND AND SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN THE PURPOSES SPECIFIED IN THIS SUBSECTION (5.5) AND IN SUBSECTION (4.5)(a) OF THIS SECTION.

(b) ALL MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND IS SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND, SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY, MUST BE EXPENDED BY THE ENTERPRISE FOR THE FOLLOWING PURPOSES:

(I) (A) TO PAY THE ADMINISTRATIVE COSTS OF IMPLEMENTING THIS SUBSECTION (5.5) AND SUBSECTION (4.5) OF THIS SECTION;

(B) TO SATISFY SETTLEMENTS OR JUDGMENTS RESULTING FROM NURSING FACILITY PROVIDER REIMBURSEMENT APPEALS; AND

(C) TO PAY A NURSING FACILITY PROVIDER A SUPPLEMENTAL MEDICAID PAYMENT FOR CARE AND SERVICES RENDERED TO MEDICAID RESIDENTS TO OFFSET PAYMENT OF THE NURSING FACILITY PROVIDER FEE. THE ENTERPRISE, IN CONSULTATION WITH THE STATE DEPARTMENT, SHALL COMPUTE THIS PAYMENT ANNUALLY, BEGINNING ON MAY 1, 2025, AND EACH JULY 1 THEREAFTER.

(II) AFTER THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBSECTION (5.5)(b)(I) OF THIS SECTION, TO PAY THE SUPPLEMENTAL MEDICAID PAYMENTS FOR ACUITY OR CASE-MIX OF RESIDENTS ESTABLISHED UNDER SECTION 25.5-6-202 (2), PRIOR TO ITS REPEAL ON JULY 1, 2026, OR AS PROVIDED IN THE RULES ADOPTED BY THE STATE BOARD PURSUANT TO SECTION 25.5-6-202 (10) AND (14)(a), IN CONSULTATION WITH THE ENTERPRISE AS PROVIDED IN SUBSECTION (7)(h)(IV) OF THIS SECTION;

(III) AFTER THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBSECTIONS (5.5)(b)(I) AND (5.5)(b)(II) OF THIS SECTION, TO PAY SUPPLEMENTAL MEDICAID PAYMENTS BASED UPON PERFORMANCE TO THOSE NURSING FACILITY PROVIDERS THAT PROVIDE SERVICES THAT RESULT IN BETTER CARE AND HIGHER QUALITY OF LIFE FOR THEIR RESIDENTS. THE ENTERPRISE, IN CONSULTATION WITH THE STATE BOARD, SHALL DETERMINE THE PAYMENT AMOUNT BASED UPON PERFORMANCE MEASURES ESTABLISHED IN RULES ADOPTED BY THE STATE BOARD IN THE DOMAINS OF QUALITY OF LIFE, QUALITY OF CARE, AND FACILITY MANAGEMENT. DURING EACH STATE FISCAL YEAR, THE ENTERPRISE MAY DISCONTINUE THE SUPPLEMENTAL MEDICAID PAYMENT ESTABLISHED PURSUANT TO THIS SUBSECTION (5.5)(b)(III) TO ANY NURSING FACILITY PROVIDER THAT FAILS TO COMPLY WITH THE ESTABLISHED PERFORMANCE MEASURES DURING THE STATE FISCAL YEAR, AND THE ENTERPRISE MAY INITIATE THE SUPPLEMENTAL MEDICAID PAYMENT ESTABLISHED PURSUANT TO THIS SUBSECTION (5.5)(b)(III) TO ANY NURSING FACILITY PROVIDER THAT COMES INTO COMPLIANCE WITH THE ESTABLISHED PERFORMANCE MEASURES DURING THE STATE FISCAL YEAR.

(IV) (A) AFTER THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBSECTIONS (5.5)(b)(I) TO (5.5)(b)(III) OF THIS SECTION, TO PAY THE SUPPLEMENTAL MEDICAID PAYMENTS TO NURSING FACILITY PROVIDERS THAT SERVE RESIDENTS WHO HAVE MODERATE TO VERY SEVERE MENTAL HEALTH CONDITIONS, DEMENTIA DISEASES AND RELATED DISABILITIES, OR ACQUIRED

BRAIN INJURY. THE ENTERPRISE, IN CONSULTATION WITH THE STATE DEPARTMENT, SHALL COMPUTE THIS PAYMENT ANNUALLY, BEGINNING ON MAY 1, 2025, AND EACH JULY 1 THEREAFTER.

(B) IF THE ENTERPRISE DETERMINES, IN CONSULTATION WITH THE STATE DEPARTMENT, THAT THE CASE-MIX REIMBURSEMENT DESCRIBED IN SUBSECTION (5.5)(b)(II) OF THIS SECTION INCLUDES A FACTOR FOR NURSING FACILITY PROVIDERS THAT SERVE RESIDENTS WITH SEVERE DEMENTIA DISEASES AND RELATED DISABILITIES OR ACQUIRED BRAIN INJURY, THE ENTERPRISE MAY ELIMINATE THIS SUPPLEMENTAL MEDICAID PAYMENT TO THOSE NURSING FACILITY PROVIDERS THAT SERVE RESIDENTS WITH SEVERE DEMENTIA DISEASES AND RELATED DISABILITIES OR ACQUIRED BRAIN INJURY.

(V) AFTER THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBSECTIONS (5.5)(b)(I) TO (5.5)(b)(IV) OF THIS SECTION, TO PAY THE SUPPLEMENTAL MEDICAID PAYMENTS FOR THE AMOUNT OF THE AGGREGATE STATEWIDE AVERAGE PER DIEM RATE OF PATIENT PAYMENT ESTABLISHED UNDER SECTION 25.5-6-202 (9), PRIOR TO ITS REPEAL ON JULY 1, 2026, OR AS PROVIDED IN THE RULES ADOPTED BY THE STATE BOARD PURSUANT TO SECTION 25.5-6-202 (10) AND (14)(a), IN CONSULTATION WITH THE ENTERPRISE AS PROVIDED IN SUBSECTION (7)(h)(IV) OF THIS SECTION.

(5.7) **Healthcare affordability and sustainability intermediate care facility fee cash fund.** (a) ALL HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEES COLLECTED PURSUANT TO THIS SECTION BY THE ENTERPRISE MUST BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE FEE TO THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE CASH FUND, WHICH FUND IS CREATED. THE STATE TREASURER SHALL CREDIT ALL INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND TO THE INTERMEDIATE CARE FACILITY CASH FUND. THE STATE TREASURER SHALL INVEST ANY MONEY IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND NOT EXPENDED FOR THE PURPOSES SPECIFIED IN SUBSECTIONS (4.7)(a) AND (5.7)(b) OF THIS SECTION AS PROVIDED BY LAW. MONEY IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND SHALL NOT BE TRANSFERRED TO ANY OTHER FUND AND SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN THE PURPOSES SPECIFIED IN THIS SUBSECTION (5.7) AND IN SUBSECTION (4.7)(a) OF THIS SECTION.

(b) ALL MONEY IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND IS SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND, SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY, MUST BE EXPENDED BY THE ENTERPRISE FOR THE FOLLOWING PURPOSES:

(I) TO PAY THE ADMINISTRATIVE COSTS OF IMPLEMENTING THIS SUBSECTION (5.7) AND SUBSECTION (4.7) OF THIS SECTION; AND

(II) TO SUPPLEMENT REIMBURSEMENTS TO INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES AS PROVIDED IN SECTION 25.5-6-204. THE ENTERPRISE, IN CONSULTATION WITH THE STATE DEPARTMENT, SHALL COMPUTE THIS PAYMENT ANNUALLY, BEGINNING ON MAY 1, 2025, AND EACH JULY 1 THEREAFTER.

(6) **Appropriations.** (a) (I) Except as otherwise provided in subsection (6)(b)(I.5) or (6)(b)(I.7) of this section, the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee is to supplement, not supplant, general fund appropriations to support hospital reimbursements. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(IV) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (5.5)(b)(V) OF THIS SECTION, THE NURSING FACILITY PROVIDER FEE IS TO SUPPLEMENT, NOT SUPPLANT, GENERAL FUND APPROPRIATIONS TO SUPPORT NURSING FACILITY PROVIDER REIMBURSEMENTS.

(V) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (5.7)(b)(II) OF THIS SECTION, THE INTERMEDIATE CARE FACILITY FEE IS TO SUPPLEMENT, NOT SUPPLANT, GENERAL FUND APPROPRIATIONS TO SUPPORT INTERMEDIATE CARE FACILITY REIMBURSEMENTS.

(b) If the revenue from the ~~healthcare affordability and sustainability~~

HOSPITAL PROVIDER fee is insufficient to fully fund all of the purposes described in subsection (5)(b) of this section:

(II) The hospital provider reimbursement and quality incentive payment increases described in subsections (5)(b)(I) to (5)(b)(III) of this section and the costs described in subsection (5)(b)(VI) of this section shall be fully funded using revenue from the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and federal matching funds before any eligibility expansion is funded; and

(III) (A) If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subsection (5)(b)(IV) of this section, and the state department thereafter notifies the enterprise board that the revenue available from the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the enterprise board shall recommend to the state board reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After receiving the recommendations of the enterprise board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue will be sufficient and shall forward any adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), following the adoption of rules pursuant to this subsection (6)(b)(III)(A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to subsection (6)(b)(III)(B) of this section.

(B) The joint budget committee shall promptly consider any rules adopted by the state board pursuant to subsection (6)(b)(III)(A) of this section. The joint budget committee shall promptly notify the state department, the state board, and the enterprise board of any action on the rules. If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility. After approving the rules pursuant to this subsection (6)(b)(III)(B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, extend the rules as provided for in section 24-4-103 (8) unless the

committee on legal services finds after review that the rules do not conform with section 24-4-103 (8)(a).

(b.5) IF THE REVENUE FROM THE NURSING FACILITY PROVIDER FEE IS INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SUBSECTION (5.5)(b) OF THIS SECTION:

(I) THE GENERAL ASSEMBLY IS NOT OBLIGATED TO APPROPRIATE GENERAL FUND REVENUES TO FUND SUCH PURPOSES; AND

(II) SUBJECT TO THE PRIORITY OF THE USES FOR THE NURSING FACILITY PROVIDER FEE AS PROVIDED IN SUBSECTION (5.5)(b) OF THIS SECTION, THE ENTERPRISE, IN CONSULTATION WITH THE STATE DEPARTMENT, MAY SUSPEND OR REDUCE ANY SUPPLEMENTAL MEDICAID PAYMENT.

(c) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for money in the HOSPITAL PROVIDER FEE CASH fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the enterprise shall cease collecting the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and shall repay to the hospitals any money received by the HOSPITAL PROVIDER FEE CASH fund that is not subject to federal matching funds.

(c.5) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, IF, AFTER RECEIPT OF AUTHORIZATION TO RECEIVE FEDERAL MATCHING FUNDS FOR MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND, THE AUTHORIZATION IS WITHDRAWN OR CHANGED SO THAT FEDERAL MATCHING FUNDS ARE NO LONGER AVAILABLE, THE ENTERPRISE SHALL CEASE COLLECTING THE NURSING FACILITY PROVIDER FEE AND SHALL REPAY TO THE NURSING FACILITY PROVIDERS ANY MONEY RECEIVED IN THE NURSING FACILITY PROVIDER FEE CASH FUND THAT IS NOT SUBJECT TO FEDERAL MATCHING FUNDS.

(c.7) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, IF, AFTER RECEIPT OF AUTHORIZATION TO RECEIVE FEDERAL MATCHING FUNDS FOR MONEY IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND, THE AUTHORIZATION IS WITHDRAWN OR CHANGED SO THAT FEDERAL MATCHING FUNDS ARE NO LONGER AVAILABLE, THE ENTERPRISE SHALL CEASE COLLECTING THE INTERMEDIATE CARE FACILITY FEE AND SHALL

REPAY TO THE INTERMEDIATE CARE FACILITIES ANY MONEY RECEIVED IN THE INTERMEDIATE CARE FACILITY FEE CASH FUND THAT IS NOT SUBJECT TO FEDERAL MATCHING FUNDS.

(7) **Colorado healthcare affordability and sustainability enterprise board.** (b) Members of the enterprise board serve without compensation but must be reimbursed from money in the HOSPITAL PROVIDER FEE CASH fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(d) The enterprise board has, at a minimum, the following duties:

(I) To determine the timing and method by which the enterprise assesses the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and the amount of the fee;

(II) If requested by the health and human services committee of the senate or the ~~public~~ health ~~care~~ and human services committee of the house of representatives, or any successor committees, to consult with the committees on any legislation that may impact the ~~healthcare affordability and sustainability fee~~ FEES, PAYMENTS, or ~~hospital~~ reimbursements established pursuant to this section;

(III) To determine changes in the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee that increase the number of hospitals benefitting from the uses of the ~~healthcare affordability and sustainability~~ fee described in subsections (5)(b)(I) to (5)(b)(IV) of this section or that minimize the number of hospitals that suffer losses as a result of paying the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee;

(IX) To monitor the impact of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee, THE NURSING FACILITY PROVIDER FEE, AND THE INTERMEDIATE CARE FACILITY FEE on the broader health-care marketplace;

(X) To establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee; and

(e) On or before January 15, 2018, and on or before January 15 each

year thereafter, the enterprise board shall submit a written report to the health and human services committee of the senate and the ~~public~~ health ~~care~~ and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:

(II) A description of the formula for how the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee is calculated and the process by which the ~~healthcare affordability and sustainability~~ fee is assessed and collected;

(II.5) A DESCRIPTION OF THE FORMULA FOR HOW THE NURSING FACILITY PROVIDER FEE IS CALCULATED AND THE PROCESS BY WHICH THE FEE IS ASSESSED AND COLLECTED;

(II.7) A DESCRIPTION OF THE FORMULA FOR HOW THE INTERMEDIATE CARE FACILITY FEE IS CALCULATED AND THE PROCESS BY WHICH THE FEE IS ASSESSED AND COLLECTED;

(III) An itemization of the total amount of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee paid by each hospital and any projected revenue that each hospital is expected to receive due to:

(III.5) AN ITEMIZATION OF THE TOTAL AMOUNT OF THE NURSING FACILITY PROVIDER FEE PAID BY EACH NURSING FACILITY PROVIDER AND ANY PROJECTED REVENUE THAT EACH NURSING FACILITY PROVIDER IS EXPECTED TO RECEIVE DUE TO INCREASED REIMBURSEMENTS AND SUPPLEMENTAL PAYMENTS MADE PURSUANT TO SUBSECTION (5.5)(b) OF THIS SECTION;

(III.7) AN ITEMIZATION OF THE TOTAL AMOUNT OF THE INTERMEDIATE CARE FACILITY FEE PAID BY EACH INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES AND ANY PROJECTED REVENUE THAT EACH INTERMEDIATE CARE FACILITY IS EXPECTED TO RECEIVE DUE TO INCREASED REIMBURSEMENTS MADE PURSUANT TO SUBSECTION (5.7)(b) OF THIS SECTION;

(IV) An itemization of the costs incurred by the enterprise in

implementing and administering the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee, THE NURSING FACILITY PROVIDER FEE, AND THE INTERMEDIATE CARE FACILITY FEE;

(h) (I) THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD IS CREATED WITHIN THE ENTERPRISE FOR THE PURPOSE OF SUPPORTING THE ENTERPRISE BOARD WITH THE IMPLEMENTATION OF THE NURSING FACILITY PROVIDER FEE AND THE INTERMEDIATE CARE FACILITY FEE. THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD CONSISTS OF EIGHT MEMBERS APPOINTED BY THE GOVERNOR, WITH THE ADVICE AND CONSENT OF THE SENATE, AS FOLLOWS:

(A) TWO MEMBERS WHO ARE REPRESENTATIVES OF NURSING FACILITY ASSOCIATIONS;

(B) TWO MEMBERS WHO ARE REPRESENTATIVES OF NURSING FACILITIES, WITH ONE MEMBER REPRESENTING A RURAL NURSING FACILITY;

(C) ONE MEMBER WHO IS A RESIDENT OF A LONG-TERM CARE FACILITY OR A CONSUMER OF LONG-TERM CARE SERVICES, OR A FAMILY MEMBER OR GUARDIAN REPRESENTING SUCH RESIDENT OR CONSUMER;

(D) ONE EMPLOYEE OF THE STATE DEPARTMENT;

(E) ONE EMPLOYEE OF THE DEPARTMENT OF HUMAN SERVICES CREATED IN SECTION 24-1-120; AND

(F) ONE EMPLOYEE OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT CREATED IN SECTION 25-1-102.

(II) (A) MEMBERS OF THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD SERVE AT THE PLEASURE OF THE GOVERNOR. ALL TERMS ARE FOR FOUR YEARS. A MEMBER WHO IS APPOINTED TO FILL A VACANCY SHALL SERVE THE REMAINDER OF THE UNEXPIRED TERM OF THE FORMER MEMBER.

(B) THE GOVERNOR SHALL MAKE THE INITIAL APPOINTMENTS TO THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD AS SOON AS PRACTICAL FOLLOWING MAY 1, 2025.

(III) THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD SHALL ELECT A CHAIR AND A VICE-CHAIR FROM AMONG ITS MEMBERS.

(IV) THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD SHALL FULFILL, AT A MINIMUM, THE FOLLOWING DUTIES ON BEHALF OF THE ENTERPRISE:

(A) TO DETERMINE THE TIMING AND METHOD BY WHICH THE ENTERPRISE ASSESSES THE NURSING FACILITY PROVIDER FEE AND THE INTERMEDIATE CARE FACILITY FEE AND THE AMOUNTS OF THE FEES;

(B) TO DETERMINE CHANGES IN THE NURSING FACILITY PROVIDER FEE THAT INCREASE THE NUMBER OF NURSING FACILITY PROVIDERS BENEFITTING FROM THE USES OF THE FEE DESCRIBED IN SUBSECTION (5.5)(b) OF THIS SECTION OR THAT MINIMIZE THE NUMBER OF NURSING FACILITY PROVIDERS THAT SUFFER LOSSES AS A RESULT OF PAYING THE NURSING FACILITY PROVIDER FEE;

(C) TO DETERMINE CHANGES IN THE INTERMEDIATE CARE FACILITY FEE THAT INCREASE THE NUMBER OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES THAT BENEFIT FROM THE USES OF THE FEE DESCRIBED IN SUBSECTION (5.7)(b) OF THIS SECTION OR THAT MINIMIZE THE NUMBER OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES THAT SUFFER LOSSES AS A RESULT OF PAYING THE NURSING FACILITY PROVIDER FEE;

(D) TO CONSULT WITH THE STATE BOARD ON THE RULES REGARDING PAYMENTS TO NURSING FACILITY PROVIDERS THAT IT ADOPTS PURSUANT TO SECTION 25.5-6-202 (10) AND (14)(a);

(E) TO CONSULT WITH THE STATE BOARD AND THE STATE DEPARTMENT ON THE RULES, PRICE SCHEDULES, AND ALLOWANCES REGARDING REIMBURSEMENT AND PAYMENTS TO INTERMEDIATE CARE FACILITIES THAT THEY ADOPT PURSUANT TO SECTION 25.5-6-204;

(F) TO ESTABLISH REQUIREMENTS FOR THE REPORTS THAT NURSING FACILITY PROVIDERS MUST SUBMIT TO THE ENTERPRISE TO ALLOW THE ENTERPRISE TO CALCULATE THE AMOUNT OF THE NURSING FACILITY PROVIDER FEE; AND

(G) TO ESTABLISH REQUIREMENTS FOR THE REPORTS THAT INTERMEDIATE CARE FACILITIES MUST SUBMIT TO THE ENTERPRISE TO ALLOW THE ENTERPRISE TO CALCULATE THE AMOUNT OF THE INTERMEDIATE CARE FACILITY FEE.

(V) MEMBERS OF THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD SERVE WITHOUT COMPENSATION BUT MUST BE REIMBURSED FROM MONEY IN THE NURSING FACILITY PROVIDER FEE CASH FUND OR THE INTERMEDIATE CARE FACILITY FEE CASH FUND FOR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES PURSUANT TO THIS SECTION.

(7.5) **Enterprise transparency and reporting.** TO ENSURE TRANSPARENCY AND ACCOUNTABILITY, AND IN ADDITION TO THE REPORT REQUIRED BY SUBSECTION (7)(e) OF THIS SECTION, THE ENTERPRISE SHALL:

(a) NO LATER THAN NOVEMBER 1, 2025, AND BY NOVEMBER 1 OF EACH THREE-YEAR PERIOD THEREAFTER, PUBLISH AND POST ON ITS WEBSITE A THREE-YEAR PLAN THAT DETAILS HOW THE ENTERPRISE WILL EXECUTE ITS BUSINESS PURPOSES DURING THE CURRENT STATE FISCAL YEAR AND THE TWO SUBSEQUENT STATE FISCAL YEARS AND THAT ESTIMATES THE AMOUNT OF FUNDING NEEDED TO IMPLEMENT THE PLAN; AND

(b) CREATE, MAINTAIN, AND REGULARLY UPDATE ON ITS WEBSITE A PUBLIC ACCOUNTABILITY DASHBOARD THAT PROVIDES, AT A MINIMUM, ACCESSIBLE AND TRANSPARENT SUMMARY INFORMATION REGARDING THE IMPLEMENTATION OF ITS THREE-YEAR PLAN, THE FUNDING STATUS AND PROGRESS TOWARD COMPLETION OF EACH PROJECT THAT IT WHOLLY OR PARTLY FUNDS, AND ITS PER-PROJECT AND TOTAL FUNDING AND EXPENDITURES.

(9) **Definitions.** AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CASE-MIX" HAS THE SAME MEANING AS SET FORTH IN SECTION 25.5-6-201 (8).

(b) "CASE-MIX REIMBURSEMENT" HAS THE SAME MEANING AS SET FORTH IN SECTION 25.5-6-201 (12).

(c) "COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE" OR "ENTERPRISE" MEANS THE ENTERPRISE CREATED IN SUBSECTION (3) OF THIS SECTION.

(d) "FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD" MEANS THE FACILITY PROVIDER FEE ENTERPRISE SUPPORT BOARD CREATED IN SUBSECTION (7)(h) OF THIS SECTION.

(e) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE" OR "HOSPITAL PROVIDER FEE" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE CHARGED AND COLLECTED AS AUTHORIZED BY SUBSECTION (4) OF THIS SECTION.

(f) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE CASH FUND" OR "HOSPITAL PROVIDER FEE CASH FUND" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY HOSPITAL PROVIDER FEE CASH FUND CREATED IN SUBSECTION (5) OF THIS SECTION.

(g) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE" OR "INTERMEDIATE CARE FACILITY FEE" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES CHARGED AND COLLECTED AS AUTHORIZED BY SUBSECTION (4.7) OF THIS SECTION.

(h) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE CASH FUND" OR "INTERMEDIATE CARE FACILITY FEE CASH FUND" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE CASH FUND CREATED IN SUBSECTION (5.7) OF THIS SECTION.

(i) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE" OR "NURSING FACILITY PROVIDER FEE" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE CHARGED AND COLLECTED AS AUTHORIZED BY SUBSECTION (4.5) OF THIS SECTION.

(j) "HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE CASH FUND" OR "NURSING FACILITY PROVIDER FEE CASH FUND" MEANS THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY

NURSING FACILITY PROVIDER FEE CASH FUND CREATED IN SUBSECTION (5.5) OF THIS SECTION.

(k) "HOSPITAL" MEANS A LICENSED OR CERTIFIED HOSPITAL.

(l) "NURSING FACILITY PROVIDER" HAS THE SAME MEANING AS SET FORTH IN SECTION 25.5-6-201 (25).

(m) "STATE MEDICAL ASSISTANCE PROGRAM" MEANS THE PROGRAM DESCRIBED IN THIS ARTICLE 4 AND ARTICLES 5 AND 6 OF THIS TITLE 25.5.

(n) "STATEWIDE AVERAGE PER DIEM RATE" HAS THE SAME MEANING AS SET FORTH IN SECTION 25.5-6-201 (35).

(o) "SUPPLEMENTAL MEDICAID PAYMENT" HAS THE SAME MEANING AS SET FORTH IN SECTION 25.5-6-201 (36).

SECTION 2. In Colorado Revised Statutes, 25.5-4-402.4, **amend** (2) introductory portion and (2)(d) introductory portion; and **amend as they will become effective July 1, 2025,** (2)(d)(I), (4)(a) introductory portion, and (4)(g)(I) as follows:

25.5-4-402.4. Healthcare affordability and sustainability hospital provider fee - healthcare affordability and sustainability nursing facility provider fee - healthcare affordability and sustainability intermediate care facility fee - Colorado healthcare affordability and sustainability enterprise - federal waiver - funds created - reports - rules - legislative declaration - repeal. (2) **Legislative declaration.** The general assembly ~~hereby~~ finds and declares that:

(d) The Colorado healthcare affordability and sustainability enterprise provides business services to hospitals when, in exchange for payment of healthcare affordability and sustainability HOSPITAL PROVIDER fees by hospitals, it:

(I) Obtains federal matching money and returns both the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee and the federal matching money to hospitals to increase reimbursement rates to hospitals for providing medical care under the state medical assistance program, including disproportionate share hospital payments pursuant to 42 U.S.C.

sec. 1396r-4, and to increase the number of individuals covered by public medical assistance; and

(4) **Healthcare affordability and sustainability fee.** (a) For the fiscal year commencing July 1, 2017, and for each fiscal year thereafter, the enterprise is authorized to charge and collect a healthcare affordability and sustainability HOSPITAL PROVIDER fee, as described in 42 CFR 433.68 (b), on outpatient and inpatient services provided by all licensed or certified hospitals ~~referred to in this section as "hospitals",~~ for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article 4 and articles 5 and 6 of this title 25.5, ~~referred to in this section as the "state medical assistance program",~~ including disproportionate share hospital payments pursuant to 42 U.S.C. sec. 1396r-4. If the amount of ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue collected exceeds the federal net patient revenue-based limit on the amount of such fee revenue that may be collected, requiring repayment to the federal government of excess federal matching money received, hospitals that received such excess federal matching money are responsible for repaying the excess federal money and any associated federal penalties to the federal government. The enterprise shall use the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee revenue to:

(g) (I) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the ~~healthcare affordability and sustainability~~ HOSPITAL PROVIDER fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(d) of this section.

SECTION 3. In Colorado Revised Statutes, 25.5-5-103, **amend** (1)(b) as follows:

25.5-5-103. Mandated programs with special state provisions - rules. (1) This section specifies programs developed by Colorado to meet federal mandates. These programs include but are not limited to:

(b) Special provisions relating to nursing facilities, as specified in ~~sections 25.5-6-201 to 25.5-6-203, 25.5-6-205, and 25.5-6-206~~ SECTIONS

25.5-4-402.4 (4.5) AND (5.5), 25.5-6-201, 25.5-6-202, 25.5-6-205, AND 25.5-6-206;

SECTION 4. In Colorado Revised Statutes, 25.5-6-202, **amend** (9)(b)(I) introductory portion, (9)(b)(II), and (9)(b)(VI); and **repeal** (5), (6), (7), (9)(b.3), and (9)(d) as follows:

25.5-6-202. Providers - nursing facility provider reimbursement - exemption - rules - repeal. (5) ~~Subject to available appropriations and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (4) of this section, the state department shall make a supplemental medicaid payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents. The state department shall determine the payment amount based upon performance measures established in rules adopted by the state board in the domains of quality of life, quality of care, and facility management. Beginning July 1, 2024, the payment must not be less than twelve percent of total provider fee payments and must be adjusted for fiscal years 2024-25 and 2025-26. No later than July 1, 2026, the payment must not be less than fifteen percent of total provider fee payments and must be annually adjusted thereafter. During each state fiscal year, the state department may discontinue the supplemental medicaid payment established pursuant to this subsection (5) to any nursing facility provider that fails to comply with the established performance measures during the state fiscal year, and the state department may initiate the supplemental medicaid payment established pursuant to this subsection (5) to any provider that comes into compliance with the established performance measures during the state fiscal year.~~

(6) ~~Subject to available appropriations and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (5) of this section, the state department shall make a supplemental medicaid payment to nursing facility providers that serve residents:~~

~~(a) Who have severe mental health conditions that are classified at a level II by the medicaid program's preadmission screening and resident review assessment tool. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it must not be~~

~~less than two percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section. Beginning July 1, 2023, the state department shall annually adjust the rate to ensure access to care for residents who have severe mental health conditions.~~

~~(b) With severe dementia diseases and related disabilities or acquired brain injury. The state department shall calculate the payment based upon the resident's cognitive assessment established in rules adopted by the state board. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it must not be less than one percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section. Beginning July 1, 2023, the state department shall annually adjust the rate to ensure access to care for residents with severe dementia diseases and related disabilities or acquired brain injury.~~

(7) ~~Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (6) of this section, the state department shall pay a nursing facility provider a supplemental medicaid payment for care and services rendered to medicaid residents to offset payment of the provider fee assessed under the provisions of section 25.5-6-203. The state department shall compute this payment annually, as of July 1, 2009, and each July 1 thereafter.~~

(9) (b) (I) Except for changes in the number of patient days, the state department shall establish the general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to subsections (1) to (4) of this section. The state's share of the reimbursement rate components pursuant to subsections (1) to (4) of this section may be funded through the provider fee assessed pursuant to ~~section 25.5-6-203~~ SECTION 25.5-4-402.4 (4.5) and any associated federal funds. Any provider fee used as the state's share and all federal funds must be excluded from the calculation of the general fund share. For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, the state department shall calculate the general fund share of the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section using the rates that were effective on July 1 of that fiscal year; except that:

(II) If the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section exceeds the general fund share, the amount of the average statewide per diem rate that exceeds the general fund share ~~shall~~ MUST be paid as a supplemental medicaid payment using the provider fee established under ~~section 25.5-6-203~~ SECTION 25.5-4-402.4 (4.5). Subject to the priority of the uses of the provider fee established under ~~section 25.5-6-203 (2)(b)~~ SECTION 25.5-4-402.4 (5.5)(b), if the provider fee is insufficient to fully fund the supplemental medicaid payment, the supplemental medicaid payment ~~shall~~ MUST be reduced to all providers proportionately.

(VI) Notwithstanding any other provision of law, for the fiscal year commencing July 1, 2013, and each fiscal year thereafter, the general fund portion of the per diem rate pursuant to subsections (1) to (4) of this section shall be reduced by one and one-half percent. The state department may, but is not required to, increase the supplemental medicaid payment pursuant to ~~subparagraph (II) of this paragraph (b)~~ SUBSECTION (9)(b)(II) OF THIS SECTION due to this reduction. ~~except that the provider fee shall not exceed the amount specified in section 25.5-6-203 (1)(a)(II).~~

(b.3) ~~(I) For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, if the provider fee established under section 25.5-6-203 is insufficient to fully fund the supplemental medicaid payments established under subsections (5) to (7) of this section, subject to the priority of the uses of the provider fee established pursuant to section 25.5-6-203 (2)(b), the state department may suspend or reduce the supplemental medicaid payment subject to the uses of the provider fee established under section 25.5-6-203.~~

~~(II) If it is determined by the state department that the case-mix reimbursement includes a factor for nursing facility providers that serve residents with severe dementia diseases and related disabilities or acquired brain injury, the state department may eliminate the supplemental medicaid payment to those providers that serve residents with severe dementia diseases and related disabilities or acquired brain injury.~~

(d) ~~The reimbursement rate components pursuant to subsections (5) to (7) of this section shall be funded entirely through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. No general fund moneys shall be used to pay for the~~

~~reimbursement rate components established pursuant to subsections (5) to (7) of this section.~~

SECTION 5. In Colorado Revised Statutes, 25.5-6-203, **repeal** (1); and **add** (2)(a.5) and (3) as follows:

25.5-6-203. Nursing facilities - provider fees - federal waiver - fund created - rules - repeal. (1) ~~(a) (I) Beginning with the fiscal year commencing July 1, 2008, and each fiscal year thereafter, the state department shall charge and collect provider fees on health-care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program as described in articles 4 to 6 of this title. As specified by the priority of the uses of the provider fee in paragraph (b) of subsection (2) of this section, the provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.~~

~~(II) For the fiscal years commencing July 1, 2009, and July 1, 2010, the provider fee shall not exceed seven dollars and fifty cents per nonmedicare-resident day. For the fiscal year commencing July 1, 2011, and each fiscal year thereafter, the provider fee shall not exceed twelve dollars per nonmedicare-resident day plus inflation based on the national skilled nursing facility market basket index as determined by the secretary of the department of health and human services pursuant to 42 U.S.C. sec. 1395yy (e)(5) or any successor index.~~

~~(III) In calculating the amount of the provider fee portion of the supplemental medicaid payments established under section 25.5-6-202 (5), the state department may include an additional amount of up to five percent of the provider fee portion of said supplemental medicaid payments to initiate the payment to any provider who complies with the established performance measures during the state fiscal year.~~

~~(b) The provider fees shall be charged on a nonmedicare-resident day basis and shall be based upon the aggregate gross or net revenue, as prescribed by the state department, of all nursing facility providers subject to the provider fee. The state department may exempt revenue categories from the gross or net revenue calculation and the collection of the provider fee from nursing facility providers, as authorized by federal law.~~

~~(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the state department shall seek a waiver from the broad-based provider fees requirement or the uniform provider fees requirement, or both, to exclude nursing facility providers from the provider fee. The state department shall exempt the following nursing facility providers to obtain federal approval and minimize the financial impact on nursing facility providers:~~

~~(A) A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102 or that provides assisted living services on-site, twenty-four hours per day, seven days per week.~~

~~(B) A skilled nursing facility owned and operated by the state;~~

~~(C) A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and~~

~~(D) A facility that has forty-five or fewer licensed beds.~~

~~(II) No later than July 1, 2026, the state department shall promulgate rules maintaining the exemptions identified in this subsection (1)(c) in order to minimize the financial impact on nursing facility providers.~~

~~(III) This subsection (1)(c) is repealed, effective July 1, 2028.~~

~~(d) The state department may lower the amount of the provider fee charged to certain nursing facility providers to meet the requirements of 42 CFR 433.68 (e) and to obtain federal approval.~~

~~(e) The imposition and collection of a provider fee shall be prohibited without the federal government's approval of a state medicaid plan amendment authorizing federal financial participation for the provider fees. The state department may alter the method prescribed in this section to the extent necessary to meet the federal requirements and to obtain federal approval.~~

~~(f) If the provider fee required by this subsection (1) is not approved by the federal government, notwithstanding any other provision of this section, the state department shall not implement the assessment or collection of the provider fee from nursing facility providers.~~

~~(g) The state department shall establish a schedule to assess and collect the provider fee on a monthly basis. The state board shall establish rules so that provider fee payments from a nursing facility provider and the state department's supplemental medicaid payments to the nursing facility are due as nearly simultaneously as feasible; except that the state department's supplemental medicaid payments to the nursing facility shall be due no more than fifteen days after the provider fee payment is received from the nursing facility. The state department shall require each nursing facility provider to report annually its total number of days of care provided to nonmedicare residents.~~

~~(h) The state department shall not assess or collect the provider fee until state medicaid plan amendments adopting the medicaid reimbursement system for the state's class I nursing facility providers, pursuant to section 25.5-6-202, including the waiver with respect to the provider fees pursuant to this section, have been approved by the federal government.~~

~~(i) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., necessary for the administration and implementation of this section.~~

~~(j) A nursing facility provider shall not include any amount of the provider fee as a separate line item in its billing statements.~~

(2) (a.5) NOTWITHSTANDING ANY PROVISION OF THIS SUBSECTION (2) TO THE CONTRARY, ON JUNE 30, 2025, THE STATE TREASURER SHALL TRANSFER THE BALANCE OF THE FUND TO THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE CASH FUND CREATED IN SECTION 25.5-4-402.4 (5.5).

(3) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2025.

SECTION 6. In Colorado Revised Statutes, 25.5-6-204, **amend** (1)(c) as follows:

25.5-6-204. Providers - reimbursement - intermediate care facility for individuals with intellectual disabilities - reimbursement - maximum allowable - repeal. (1) (c) ~~(I) Beginning in fiscal year 2013-14, and for each fiscal year thereafter, the state department is authorized to charge both privately owned intermediate care facilities for individuals with intellectual disabilities and state-operated intermediate care facilities for individuals with intellectual disabilities a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for individuals with intellectual disabilities. The service fee charged by the state department pursuant to this paragraph (c) will be assessed pursuant to rules adopted by the state board but must not exceed five percent of the total costs incurred by all intermediate care facilities for the fiscal year in which the service fee is charged. The state board shall adopt rules consistent with federal law in order to implement the provisions of this paragraph (c).~~

(II) ~~The moneys collected in each fiscal year pursuant to subparagraph (I) of this paragraph (c) shall be transmitted by the state department to the state treasurer, who shall credit the same to~~ The service fee fund ~~which fund~~ is ~~hereby~~ created and referred to in this ~~paragraph (c)~~ SUBSECTION (1)(c) as the "fund". The ~~moneys~~ MONEY in the fund shall be subject to annual appropriation by the general assembly to the state department to be used toward the state match for the federal financial participation to reimburse intermediate care facilities for individuals with intellectual disabilities pursuant to this section. Any unexpended and unencumbered ~~moneys~~ MONEY remaining in the fund at the end of any fiscal year shall remain in the fund and not be credited or transferred to the general fund or any other fund.

(III) (A) NOTWITHSTANDING ANY PROVISION OF THIS SUBSECTION (1)(c) TO THE CONTRARY, ON JUNE 30, 2025, THE STATE TREASURER SHALL TRANSFER THE BALANCE OF THE SERVICE FEE FUND TO THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY FEE CASH FUND CREATED IN SECTION 25.5-4-402.4 (5.7).

(B) THIS SUBSECTION (1)(c) IS REPEALED, EFFECTIVE JULY 1, 2025.

SECTION 7. In Colorado Revised Statutes, 25.5-6-210, **amend** (4)(b) as follows:

25.5-6-210. Additional supplemental payments - nursing facilities - funding methodology - reporting requirement - rules - repeal. (4) (b) For the purposes of federal upper payment limit calculations, the state department shall pursue federal matching funds for payments made pursuant to this section but only after securing federal matching funds for payments outlined in ~~sections 25.5-6-203 (2)~~ SECTIONS 25.5-4-402.4 (5.5)(b) and 25.5-6-208.

SECTION 8. In Colorado Revised Statutes, 25-3-108, **amend** (7) as follows:

25-3-108. Receivership. (7) The department of public health and environment shall grant the receiver a license pursuant to section 25-3-102 and shall recommend certification for medicaid participation, and the department of health care policy and financing AND THE COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE shall reimburse the receiver for the long-term health-care facility's medicaid residents pursuant to ~~section~~ SECTIONS 25.5-6-204 ~~C.R.S.~~ AND 25.5-4-402.4 (5.7).

SECTION 9. In Colorado Revised Statutes, **amend** 2-3-119 as follows:

2-3-119. Audit of healthcare affordability and sustainability hospital provider fee - cost shift. At the discretion of the legislative audit committee, the state auditor shall conduct or cause to be conducted a performance and fiscal audit of the healthcare affordability and sustainability HOSPITAL PROVIDER fee established pursuant to section 25.5-4-402.4.

SECTION 10. In Colorado Revised Statutes, 7-121-401, **amend** (33.5)(b)(V) as follows:

7-121-401. General definitions. As used in articles 121 to 137 of this title 7, unless the context otherwise requires:

(33.5) (b) Notwithstanding subsection (33.5)(a) of this section, "residential nonprofit corporation" does not include:

(V) A continuing care retirement community, as described in ~~section~~

~~25.5-6-203, C.R.S.~~ SECTION 25.5-4-402.4 (4.5)(d)(II)(A), operated by an entity that is licensed or otherwise subject to state regulation.

SECTION 11. In Colorado Revised Statutes, 10-16-1205, **amend** (5)(a) as follows:

10-16-1205. Health insurance affordability fee - special assessment on hospitals - allocation of revenues. (5) (a) The special assessments on hospitals under subsection (1)(a)(II) of this section must comply with and not violate 42 CFR 433.68. If the federal centers for medicare and medicaid services in the United States department of health and human services informs the state that the state will not be in compliance with 42 CFR 433.68 as a result of the special assessment on hospitals pursuant to subsection (1)(a)(II) of this section, the enterprise shall reduce the amount of the special assessment as necessary to avoid any reduction in the healthcare affordability and sustainability HOSPITAL PROVIDER fee collected pursuant to section 25.5-4-402.4.

SECTION 12. In Colorado Revised Statutes, 25.5-4-402.8, **amend** (2)(g)(I) as follows:

25.5-4-402.8. Hospital transparency report and requirements - definitions. (2) (g) (I) If a hospital does not provide all of the information required pursuant to subsection (2)(b) of this section, the state department shall inform the hospital of its noncompliance within sixty days and identify the information that needs to be provided. If a hospital does not comply, the state department shall issue a corrective action plan with a timeline of sixty days required for compliance. If a hospital continues to not comply, the state department may create a mandatory pay-for-reporting compliance measure within the hospital transformation program that is tied to the healthcare affordability and sustainability HOSPITAL PROVIDER fee supplemental payment and is based on compliance with subsection (2)(b) of this section.

SECTION 13. In Colorado Revised Statutes, 25.5-5-201, **amend** (1)(o)(II) and (1)(r)(II) as follows:

25.5-5-201. Optional provisions - optional groups - rules. (1) (o) (II) Notwithstanding the provisions of subsection (1)(o)(I) of this section, if the money in the healthcare affordability and sustainability

HOSPITAL PROVIDER fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title 25.5, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered or the percentage of the federal poverty line to below four hundred fifty percent or may eliminate this eligibility group.

(r) (II) Notwithstanding the provisions of subsection (1)(r)(I) of this section, if the money in the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered, or the percentage of the federal poverty line, or may eliminate this eligibility group.

SECTION 14. In Colorado Revised Statutes, 25.5-5-204.5, **amend** (2) as follows:

25.5-5-204.5. Continuous eligibility - children. (2) Notwithstanding the provisions of subsection (1) of this section, if the money in the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may eliminate the continuous enrollment requirement pursuant to this section.

SECTION 15. In Colorado Revised Statutes, 25.5-6-1403, **amend** (5)(b) as follows:

25.5-6-1403. Waivers and amendments. (5) (b) The state department shall not prepare and submit the amendments to the state medical assistance plan pursuant to this subsection (5) if there are insufficient revenues from the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund, created in section 25.5-4-402.4, for the administrative expenses associated with preparing and submitting the state plan amendments. If there are insufficient revenues from the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund, the state department may accept and expend gifts, grants, or donations for this purpose.

SECTION 16. In Colorado Revised Statutes, 25.5-8-103, **amend** (4)(a)(II) and (4)(b)(II) as follows:

25.5-8-103. Definitions - rules. As used in this article 8, unless the context otherwise requires:

(4) "Eligible person" means:

(a) (II) Notwithstanding the provisions of subsection (4)(a)(I) of this section, if the money in the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons less than nineteen years of age, the state board may by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) reduce the percentage of the federal poverty line to below two hundred sixty percent, but the percentage shall not be reduced to below two hundred thirteen percent.

(b) (II) Notwithstanding the provisions of subsection (4)(b)(I) of this section, if the money in the healthcare affordability and sustainability HOSPITAL PROVIDER fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section

25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for pregnant women, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the percentage of the federal poverty line to below two hundred sixty percent, but the percentage shall not be reduced to below two hundred thirteen percent.

SECTION 17. Appropriation - adjustments to 2025 long bill. (1) To implement this act, appropriations made in the annual general appropriation act for the 2025-26 state fiscal year to the department of health care policy and financing from the Medicaid nursing facility cash fund created in section 25.5-6-203 (2)(a), C.R.S., are decreased as follows:

Executive director's office, general administration	
Personal services	$246,811
Health, life, and dental	$30,953
Short-term disability	$65
Paid family and medical leave insurance	$1,153
Unfunded liability amortization equalization disbursement payments	$15,605
Salary survey	$6,899
Step pay	$461
PERA direct distribution	$5,026
Workers' compensation	$788
Operating expenses	$13,200
Payment to risk management and property funds	$772
Leased space	$17,191
Payments to OIT	$59,513
CORE operations	$123
General professional services and special projects	$1,250
Executive director's office, utilization and quality review contracts	
Professional services contracts	$36,875
Executive director's office, provider audits and services	
Professional audit contracts	$12,420

Executive director's office, indirect cost recoveries	
Indirect cost assessment	$12,116
Medical services premiums	
Medical and long-term care services for Medicaid eligible individuals	$62,525,000

(2) For the 2025-26 state fiscal year, $62,986,221 is appropriated to the department of health care policy and financing. This appropriation is from the healthcare affordability and sustainability nursing facility provider fee cash fund created in section 25.5-4-402.4 (5.5)(a), C.R.S. To implement this act, the department may use this appropriation as follows:

Executive director's office, general administration	
Personal services	$246,811
Health, life, and dental	$30,953
Short-term disability	$65
Paid family and medical leave insurance	$1,153
Unfunded liability amortization equalization disbursement payments	$15,605
Salary survey	$6,899
Step pay	$461
PERA direct distribution	$5,026
Workers' compensation	$788
Operating expenses	$13,200
Payment to risk management and property funds	$772
Leased space	$17,191
Payments to OIT	$59,513
CORE operations	$123
General professional services and special projects	$1,250
Executive director's office, utilization and quality review contracts	
Professional services contracts	$36,875
Executive director's office, provider audits and services	
Professional audit contracts	$12,420
Executive director's office, indirect cost recoveries	
Indirect cost assessment	$12,116

Medical services premiums

Medical and long-term care services for Medicaid eligible individuals	$62,525,000

(3) To implement this act, appropriations made in the annual general appropriation act for the 2025-26 state fiscal year to the department of health care policy and financing from the service fee fund created in section 25.5-6-204 (1)(c)(II), C.R.S., are decreased as follows:

Executive director's office, general administration

Personal services	$36,476
Health, life, and dental	$4,955
Short-term disability	$15
Paid family and medical leave insurance	$169
Unfunded liability amortization equalization disbursement payments	$2,287
Salary survey	$1,150
Step pay	$67
PERA direct distribution	$737
Workers' compensation	$116
Operating expenses	$1,876
Payment to risk management and property funds	$114
Leased space	$2,371
Payments to OIT	$8,789
CORE operations	$18

Executive director's office, indirect cost recoveries

Indirect cost assessment	$1,778

Medical services premiums

Medical and long-term care services for Medicaid eligible individuals	$200,460

Transfers to other state department Medicaid-funded programs, human services

Regional centers for people with developmental disabilities	$1,888,903

(4) For the 2025-26 state fiscal year, $2,150,281 is appropriated to

the department of health care policy and financing. This appropriation is from the healthcare affordability and sustainability intermediate care facility fee cash fund created in section 25.5-4-402.4 (5.7)(a), C.R.S. To implement this act, the department may use this appropriation as follows:

Executive director's office, general administration	
Personal services	$36,476
Health, life, and dental	$4,955
Short-term disability	$15
Paid family and medical leave insurance	$169
Unfunded liability amortization equalization disbursement payments	$2,287
Salary survey	$1,150
Step pay	$67
PERA direct distribution	$737
Workers' compensation	$116
Operating expenses	$1,876
Payment to risk management and property funds	$114
Leased space	$2,371
Payments to OIT	$8,789
CORE operations	$18
Executive director's office, indirect cost recoveries	
Indirect cost assessment	$1,778
Medical services premiums	
Medical and long-term care services for Medicaid eligible individuals	$200,460
Transfers to other state department Medicaid-funded programs, human services	
Regional centers for people with developmental disabilities	$1,888,903

		APPROPRIATION FROM				
ITEM & SUBTOTAL	TOTAL	GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
$	$	$	$	$	$	$

SECTION 18. Appropriation to the department of health care policy and financing for the fiscal year beginning July 1, 2024. In Session Laws of Colorado 2024, section 2 of chapter 519, (HB 24-1430), **amend** Part VI (2) and (7)(C)(6), as Part VI (2) and the affected totals are amended by section 1 of SB 25-093, as follows:

Section 2. **Appropriation.**

PART VI

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(2) MEDICAL SERVICES PREMIUMS

Medical and Long-Term Care Services for Medicaid Eligible Individuals[24a]	12,081,998,495	2,376,915,878(M)	1,247,280,333[a]	1,399,855,214[b]	119,588,730[c]	6,938,358,340

[a] This amount shall be from the General Fund Exempt Account created in Section 24-77-103.6 (2), C.R.S.

		APPROPRIATION FROM				
ITEM & SUBTOTAL	TOTAL	GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
$	$	$	$	$	$	$

[b] Of this amount, $1,062,923,207 shall be from the Healthcare Affordability and Sustainability Fee Cash Fund created in Section 25.5-4-402.4 (5)(a), C.R.S., $76,010,738 shall be from recoveries and recoupments, ~~$58,197,249~~ $48,415,351 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2)(a), C.R.S., $54,010,364 represents public funds certified as expenditures incurred by public emergency medical transportation providers, $52,400,466 shall be from the Adult Dental Fund created in Section 25.5-5-207 (4)(a), C.R.S., $46,929,200 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2)(a)(I), C.R.S., $24,736,077 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program, $20,376,822 shall be from the Home- and Community-based Services Improvement Fund created in Section 25.5-6-1805 (1), C.R.S., $9,781,898 SHALL BE FROM THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY NURSING FACILITY PROVIDER FEE CASH FUND CREATED IN SECTION 25.5-4-402.4 (5.5)(a), C.R.S., $1,491,000 shall be from the Tobacco Tax Cash Fund created in section 24-22-117 (1)(a), C.R.S., and meets the requirement to appropriate a portion of the revenues collected from the imposition of additional state cigarette and tobacco taxes to the Old Age Pension program for health related purposes pursuant to Section 21 of Article X of the State Constitution, $857,151 shall be from the Tobacco Education Programs Fund created in Section 24-22-117 (2)(c)(I), C.R.S., $700,000 shall be from an intergovernmental transfer from Denver Health, $550,798 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8)(a)(I), C.R.S., $471,682 shall be from the ARPA Home- and Community-Based Services Account created in Section 25.5-4-402.4 (5)(c)(I)(A), C.R.S., and $200,460 shall be from the Service Fee Fund created in Section 25.5-6-204 (1)(c)(II), C.R.S.

[c] Of this amount, $107,671,715 shall be transferred from the Department of Higher Education from the Fee-for-service Contracts with State Institutions for Speciality Education Programs line item, $9,253,841 shall be transferred from the Old Age Pension State Medical Program line item appropriation in the Other Medical Services division of this department, $1,505,000 shall be from the Department of Early Childhood from the Home Visiting line item, and $1,158,174 shall be transferred from Public School Health Services line item in the Other Medical Services division of this department.

	ITEM & SUBTOTAL	TOTAL	APPROPRIATION FROM GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
	$	$	$	$	$	$	$
(7) TRANSFERS TO OTHER STATE DEPARTMENT MEDICAID-FUNDED PROGRAMS							
(C) Human Services							
(6) Office of Adults, Aging and Disability Services							
Administration	505,357		252,679(M)				252,678
Regional Centers for People with Developmental Disabilities	58,276,921		27,249,558(M)		1,888,903[a]		29,138,460
Community Services for the Elderly	1,001,800		500,900(M)				500,900
	59,784,078						

[a] ~~This~~ OF THIS amount $1,530,432 shall be from the Service Fee Fund created in Section 25.5-6-204 (1)(c)(II), C.R.S., AND $358,471 SHALL BE FROM THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY INTERMEDIATE CARE FACILITY CASH FUND CREATED IN SECTION 25.5-4-402.4 (5.7)(a), C.R.S.

			APPROPRIATION FROM				
	ITEM & SUBTOTAL	TOTAL	GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
	$	$	$	$	$	$	$
TOTALS PART VI (HEALTH CARE POLICY AND FINANCING)[30]		$16,304,072,844	$3,819,066,512	$1,247,571,367[a]	$1,913,251,446[b]	$137,592,164	$9,186,591,355[c]

[a] Of this amount, $1,247,280,333 shall be from the General Fund Exempt Account created in Section 24-77-103.6 (2), C.R.S., and $291,034 shall be General Fund Exempt pursuant to Section 24-22-117 (1)(c)(I)(B.5), C.R.S. Said $291,034 is not subject to the statutory limitation on General Fund appropriations imposed by Section 24-75-201.1, C.R.S.

[b] Of this amount, $19,254,185 contains an (I) notation.

[c] Of this amount, $438,736,989 contains an (I) notation.

SECTION 19. Effective date. This act takes effect May 1, 2025.

SECTION 20. Safety clause. The general assembly finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety or for appropriations for the support and maintenance of the departments of the state and state institutions.

James Rashad Coleman, Sr.
PRESIDENT OF
THE SENATE

Julie McCluskie
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Esther van Mourik
SECRETARY OF
THE SENATE

Vanessa Reilly
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED Wednesday April 30th 2025 at 3:00 PM
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO